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WESTERN MICHIGAN UNIVERSITY

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Based on a presentation made to the WMU Center for the Study of Ethics in Society

September 21, 1994

MICHIGAN'S DEADLOCKED COMMISSION ON DEATH AND DYING: A LESSON IN POLITICS AND LEGALISM[1]

With the election of Nov. '94 and the end of the 1993-1994 legislative session, it now appears evident that the Michigan legislature, probably with little study or discussion, will eventually re-enact the state's presumably[2] expired absolute prohibition on assisted suicide. Though public as well as medical opinion seems as divided and uncertain as ever,[3] in the state legislature those opposing assisted suicide seem to have won a clear majority. Thoughtful, balanced legislation which would provide relief of suffering while avoiding certain dangers seen by some, is evidently not in danger of being enacted or even presented. Thus a brief window of opportunity to rationalize Michigan law, which opened with the creation of the Michigan Commission on Death and Dying, appears to have closed, if not irrevocably at least for the foreseeable future. The reasons for this are no doubt many, but perhaps some of the blame can be laid to the working of the Commission itself. Created to guide the legislature on this controversial and

emotionally-charged issue, the commission's 22 members failed to arrive at a consensus position, and instead of offering clear guidance, produced three proposals, none of which received more than nine votes. Even more serious from the point of view of those favoring at least some right to assisted suicide, none of the three proposals could be taken seriously as the basis for possible legislation; only one actually recommended decriminalizing assisted suicide, and this was so covered with qualifications and restrictions as to raise questions whether it would enable those in need to take advantage of the right, or discourage them from doing so.

This paper is an analysis of the commission's proposals and of the shifting alliances of its members as reflected in the voting. There is no attempt to draw a moral, other than to regret the loss of an opportunity to liberalize the law and offer some hope of relief from suffering to people in need.

Before turning to the Commission, it might be useful to call attention to two news stories that were reported while the Commission was doing its work.

In July the NY Times reported that an 85-year old woman in Vermont had committed suicide by starving herself to death. Though in good health, as the Times put it, her eyesight had begun to fail and she had undergone difficult bladder surgery followed by colon surgery, incontinence and pneumonia. She celebrated her 85th birthday, made a last meal of birthday cake, and then refused all further nutrition. Her physician attended with morphine as necessary for discomfort; she died peacefully in her sleep after 6 days of fasting. The Times gave her story nearly 10 column inches.[4]

Mrs. Eddy was luckier, or cleverer, than many of the AIDS victims studied by a researcher in Vancouver, B.C. He found that half of the 34 assisted suicides he was able to identify were botched. In five cases the victims were unsuccessfully suffocated; in another an attempt was made to slit the victim's wrists with a razor blade; in two cases heroin was injected unsuccessfully; in another case, massive doses of morphine, "a month's supply," were given over a period of four days before death occurred. Similar reports surface elsewhere. "One ethicist told of a man in Illinois who tried to smother

his lover with a pillow but ended up asphyxiating him just enough to destroy most of his brain's functions. A New York doctor told of a friend who tried to kill himself by overdosing on his TB medication. He tried a second time on Darvon, and failed again."[5]

Mrs. Eddy's son is a medical doctor who wrote up his mother's death in the JAMA.[6] It seems that his mother was sicker than the Times' report acknowledged. "She developed oral thrush, apparently due to the antibiotic treatment for her diarrhea, and her antidepressants got out of balance...she became anemic, which was treated with iron, which made her nauseated. She could not eat, she got weak, her skin itched, and her body ached...they found a lump in her breast and atrial fibrillation." After a cholecystectomy, Mrs. Eddy needed second surgery for rectal prolapse. "She especially hated the thought of more surgery and the intense postoperative fatigue. On the other hand the prolapse was very painful...She knew that she could not possibly walk...again unless it was fixed...Her main concern was to avoid incontinence." Mrs. Eddy decided to have the rectal surgery, which left her "totally incontinent

'at both ends,' as she put it. She was bed-ridden, anemic, exhausted, nauseated, achy, itchy...her eyesight had begun to fail...she could no longer read."

Mrs. Eddy and her son discussed Final Exit and found it of little use: "Patients can rarely get the pills, especially...in a nursing home...Anyone who provides the pills...can be arrested...Even if...the pills are available, they can be difficult to take, especially by the frail. Most likely, my mother would fall asleep before she could swallow the full dose..."

Starvation turns out to be the only solution. In a passage quoted in the Times, Dr. Eddy celebrates his mother's death: "Without hoarding pills, without making me a criminal, without putting a bag over her head, and without huddling in a van with a carbon monoxide machine, she had found a way to bring her life gracefully to a close," he wrote. "This death was not a sad death, it was a happy death. It did not come after years of decline, lost vitality, and loneliness, it came at the right time."

Dr. Eddy's reference to a van with a carbon

monoxide machine is of course an allusion to Dr. Jack Kevorkian, who was recently acquitted by a Michigan jury of the felony of "assistance to suicide" in the death of Thomas Hyde, a victim of advanced amyotrophic lateral sclerosis. Dr. Kevorkian had admitted to placing, in his van, a mask connected to a carbon monoxide machine over Hyde's face and putting in Hyde's hand the string by which the machine is operated.[7]

Mrs. Eddy's death and the botched attempts of the AIDS victims provide real-life counterpoint to the opinion of the famous anti-establishment psychiatrist, Dr. Thomas Szasz. Writing in the libertarian magazine Reason, Szasz castigates Dr. Kevorkian as "dangerous," "ominous," "a threat," impugns Kevorkian's "purported compassion," and remarkably implicates Kevorkian as a participant in what Szasz calls "medicine's war on freedom and self-determination." The threat is not that doctors wish to kill people, but that they wish to control the means by which this is to be done. But he does not actually advocate that because their motive is self-aggrandizement, not compassion, doctors must be prevented from assisting in

suicide. His solution is the free market. "[T]he fact is that neither killing another, nor killing oneself, nor helping a person kill himself requires medical expertise," Szasz writes. "Giving a person a drug to help him commit suicide is like giving him liquor to help him become drunk...Judging by published reports, the persons whom Kevorkian has 'assisted' could have ingested a fatal dose of a lethal drug, had they access to such a drug and the courage to use it. The fact that drugs used for committing suicide are now available by prescription only is a cultural-legal artifact. Prior to 1914, lethal drugs, like other consumer products, were available on the free market."[8] Whether doctors could safely be allowed to administer these drugs or at least advise on their use without jeopardizing everyone's freedom, Dr. Szasz does not say. Surprisingly, he fails to mention self-starvation as a method of free market self-help even simpler than drugs.

The Michigan Commission on Death and Dying was established by the state legislature to guide it in its deliberations on the problem presented to it by Dr Kevorkian. The same legislation[9] establishing the Commission also created the

felony of "assistance to suicide," under which Dr. Kevorkian was unsuccessfully prosecuted (before the enactment of the special statute, two attempts were made to prosecute him for murder, but to date these have not survived court challenge).[10] His acquittal made it certain that no one else would be prosecuted under the statute, which in any case was enacted as a temporary expedient. Before its presumed expiration, the statute had been declared unconstitutional for technical reasons by four Michigan courts, but the Michigan Supreme Court, pending its own review (oral arguments was held in October), in June stayed the Appeals Court order barring enforcement. (A Federal court in the state of Washington has ruled that a similar statute there violates the Federal Constitution's right to privacy.[11] The Michigan Court of Appeals, in voiding the statute on technical grounds, held, somewhat gratuitously, that the right to privacy did not extend to assistance to suicide).[12]

The membership of the commission was established by the statute, and consisted of 22 organizations (see Appendix) which have an interest in the question. Religious groups were

conspicuously omitted, though a Roman Catholic priest served as representative of a secular organization.[13] Each organization, among them the Michigan Association of Suicidology, an anti-suicide group claiming "approximately seventy-five members,"[14] had one vote. Though created with fairness and breadth in mind, the composition of the Commission did not in the end please everyone, notably certain disability advocates, some of whom tend to regard assisted suicide as a method of disposing of the unvalued disabled, and who proposed via picketing and disruption[15] that the entire commission membership be replaced by people with disabilities.[16] Not all the member groups took a position, notably two of the most influential, the Michigan State Medical Society and the Prosecuting Attorneys Association, both of whom cited disagreement among their members as the reason not to commit themselves.[17] (The representative of the state Medical Society, who was also the commission's chair, abstained on all votes; however the Prosecuting attorneys allowed their representative to vote his conscience, which he did against the proposal decriminalizing "aid-in-dying" and for the proposal to make the

prohibition permanent). The work of the commission proceeded in the usual manner: open meeting, public forums and presentations, scrutiny of documents, subcommittee reports etc.[18] But the principle on which the commission's membership was determined and the inability of influential member organizations to take a position virtually guaranteed that the commission would be deadlocked, as it was.

The commission did reach consensus on several points, none more important than that some public policy was required. The relevant statement is worth quoting in full. "**A significant conclusion reached by the Commission is that some permanent policy regarding assisted suicide should be enacted by the Legislature. The Commission views the current situation, whereby the ban on assisting suicide is scheduled to sunset six months after this report is issued, as untenable.** There have been proponents speaking before the Commission who have favored this "No law" option. The Commission felt very strongly that this option would be irresponsible as a matter of public policy and would create tremendous confusion for the

people of the state. A motion was made and approved...to eliminate the "No law" option as an advisable recommendation to the Legislature." (Report, Part II).[19]

In addition, the Commission unanimously endorsed 13 "points of consensus" ranging from public education on advance health care directives, to easing access to pain medication.[20]

The commission considered three proposals on the question of assisted suicide. The first, recommending decriminalization with safeguards, and including a model "death with dignity" act, received only 9 votes of the 22 member commission. Seven members voted against and 6 either were absent or abstained. The second proposal, "Procedural Safeguards," neither endorsed nor opposed decriminalization, but recommended a set of safeguards should the Legislature decide to decriminalize. This also received 9 votes, of whom only 4 had voted for proposal one; five members voted against and 7 were not present or abstained. Finally, there was a third report, "opposing legalized assisted suicide;" this received 5 votes for, 9 against, the

others absent or abstaining.

The same five votes cast in favor of the proposal opposing legalization, also were cast against the proposal to decriminalize. There were the "hard-core" votes opposed to legalization. They were the suicidology group, the Council for Independent Living, the Head Injury Survivor's Council, The Prosecutors' Association representative, and Right to Life, the anti-abortion group.

The other two votes against decriminalization-with-safeguards came from the osteopathic physicians and surgeons association, and the Michigan Hospice Organization. Both of these groups abstained on the second and third proposals. Hospice explained this seemingly inconsistent position as follows: "Rather than supporting legislation dealing with assisted suicide, the MHO supports legislation which requires education to address pain and symptom control and holistic, supportive care for those with terminal illness and their families." MHO pointed out that the 13-point consensus statement contains much of their position.[21] It would seem, nonetheless, that to oppose

decriminalization is, at least by implication, to favor continuing at least some form of the present ban.

There was a bloc of nine organizations that voted yes for the first proposal, decriminalization-with-safeguards, and against the third, to oppose legalization. No other organization voted either for the first nor against the third; these nine organizations thus constituted a consistent plurality on the commission in favor of liberalizing the law, a plurality which, however, was unable to attract the three additional votes needed to become a majority. They are: the Civil Liberties Union (ACLU), Health Care Association, Hemlock, the associations representing nurses, psychiatrists,[22] psychologists, and social workers, the Senior Advocates Council[23] and the State Bar.[24]

The most interesting proposal in some ways was the second, the procedural safeguards proposal, which neither endorsed nor opposed assisted suicide but recommends safeguards should the Legislature decide to decriminalize. This report was largely the work of advocates for the disabled. The disability community struggled

with the problem of assistance to suicide, but was unable to reconcile the promise of offering to the disabled greater control over their own lives with the fear of reinforced social stereotypes and negative valuations of disabled people. Thus both the head injuries group and the independent living council formed part of the hard core opposition to assisted suicide, both groups opposing decriminalization and supporting continuation of the ban, while the long-term care group and the retarded citizens group (ARC-Michigan) took no position on either decriminalization or permanent prohibition. The Council for Independent Living explained its position in a statement describing its aim as "to facilitate the unity and empowerment of people with disabilities." This they explain as "self-determination and having both the right and the opportunity to make decisions about the issues that affect one's life." They pointed out that assisted suicide could be regarded as a form of self-determination, but feared that a public policy allowing it as an option will reinforce stereotypes which work against disabled people. "These advocates feel that by permitting some form of assisted suicide available only to people with disabilities and

chronic illness, the Michigan legislature will both provide a subtle coercion for people with disabilities and chronic illness to end their lives and open the door to active euthanasia in which the decision to end an individual's life is made by the medical establishment or dictated by social norms."[25]

Proposal two recommended safeguards without either endorsing or rejecting assisted suicide. Three of the five hard-core pro-ban groups (suicidology, independent living, head injury) voted yes on proposal two. This position is at least consistent: no decriminalization, continuation of the ban, but safeguards should decriminalization be adopted. Of the other two hard-core groups, Right to Life Michigan (RLM) voted against proposal two and the prosecuting attorneys abstained, each perhaps fearing that a yes vote could implicitly be seen as endorsing assisted suicide.[26] By isolating itself from its allies in the disabled community, RLM demonstrated its more categorical opposition to assisted suicide. The other two groups who voted no on decriminalization, hospice and the osteopaths, abstained on continuing the present ban; the osteopaths also abstained on proposal

two, but hospice voted yes.

The plurality decriminalization alliance split on proposal two: the ACLU, Hemlock, the psychiatrists, and the state bar joined RLM and voted no, the health care association, nurses, social workers and Senior advocates voted yes, and the psychologists abstained. The other five yes votes on proposal two came from three of the hard-core opponents of assisted suicide, plus hospice and better care (the long-term care advocacy group). Both these groups abstained on continuing the ban; hospice voted against, better care abstained, on decriminalization.

These shifting coalitions, and the reasons for the votes, indicate the difficulty of reaching consensus. First, fully five of the 22 members either abstained or were not present for all three votes; two groups (the long-term care group Better Care and the osteopaths) abstained on two of the votes, and three other groups (hospice, psychiatrists, prosecutors) abstained once. Thus ten groups were unable to reach a position on at least one of three proposals. Second, apart from the five total abstainers, no more than four organizations adopted common positions on all

three votes: health care, nurses, seniors and social workers voted yes on 1 and 2, no on 3; ACLU, Hemlock, psychiatrists and the sate bar voted yes on 1, no on 2 and 3. Another set of three organizations voted no on 1, yes on 1 and 2: suicidology, independent living, and head injuries. That is to say, of the 17 groups voting on at least one proposal, no more than 4 voted the same way on all three proposals. (This does not of course take into account unreported straw votes and other informal measures of viewpoint).

in table form:

1	2	3	
Y	Y	N	health care, nurses, seniors, social work
Y	N	N	ACLU, Hemlock, psychiatrists, state Bar
N	Y	Y	suicidology, independent living, head injuries
N	N	Y	Right to Life
A	Y	A	better care
N	A	A	osteopaths
N	Y	A	hospice
Y	A	N	psychologists
N	A	Y	prosecutors

Of course the second proposal complicated matters, splitting both the 9 member pro group and the 5 member anti group. Ironically Right to Life joined the most liberal groups, ACLU and Hemlock, in voting against proposal two. However the second proposal was in a sense the common ground proposal, neither endorsing nor rejecting assisted suicide but specifying what everyone had agreed on in principle already, the need for legislation with safeguards and conditions. That even this proposal fared no better than the others, gaining only 9 of a possible 22 votes, is significant. Though all favor some kind of legislation, some who are opposed to decriminalization will not consider safeguards even hypothetically; some who favor decriminalization oppose safeguards they regard as unduly burdensome; others so fear abuse that the safeguards they endorse would make the decriminalization almost worthless.

Since the clear middle-ground position is decriminalization with safeguards, I shall next examine the safeguards developed in the first two proposals. There are some differences between the two proposals but it is difficult to say which set of safeguards is stricter. I shall

quote from the summary of the decriminalization proposal, the "death with dignity" act:

"Only persons who have a terminal condition (an incurable or irreversible condition which would likely result in death within six months) or a condition involving irreversible suffering (an irreversible, progressive, debilitating or degenerative disease with unbearable or unacceptable suffering emanating from a physical condition) would qualify for aid-in-dying. Someone suffering from a solely psychological condition (such as situational depression) would NOT be eligible.

"Before any aid-in-dying is given, a person must....
-Record an official request for assistance, witnessed by two unrelated, disinterested persons.
-Be examined and counseled by two physicians to determine if the person has an eligible condition and to explore all possible alternatives...
-Be examined by a psychiatrist or psychologist, to determine the person's mental competence.
-Be counseled by a social worker to explore

social service and support services which might assist the person in living in comfort and dignity.

-Be counseled by a professional in pain management or a certified hospice professional, where appropriate, to explore options that might alleviate suffering.

-Have compliance with this process certified by the probate court.

-Make two further direct requests for aid-in-dying to the attending physician witnessed by two unrelated, disinterested persons, with a waiting period of 7 days between the requests."

I am not, as the humor columnist says, making this up. And please understand that this is the proposal supported by the ACLU and Hemlock, the most ardent supporters of decriminalization. The alternative "procedural safeguards" proposal, developed by the Council for Independent Living and ARC-Michigan (retarded citizens), though explicitly written to protect disabled people whose lives are said to be put in jeopardy by decriminalization of assisted suicide, is in some ways more liberal, but in other ways stricter, than the decriminalization model statute. (The title of the alternative proposal is

"Procedural Safeguards against the Exploitation of Personal Autonomy and Vulnerability in the Decision to Terminate One's Life".)[27] Eligibility is based on "irreversible suffering from a physical condition at a level which the individual finds unbearable." This delightfully vague statement seems to allow more opportunity for the individual to decide how much suffering is enough, compared with the decriminalization proposal which says the suffering must "emanate" from a physical condition as described. Under procedures, in addition to the patient's assertion of his/her request witnessed by two impartial witnesses, there are four required consultations. Before each consultation the patient must "reaffirm his or her intent to continue with the process." This is done (each time) by completing a form whose content is specified. Before each consultation the patient must also request a "treatment summary" be sent to the consulting professional.

The consultations are with a physician who not only verifies the condition but is given several other powers and responsibilities including "to document barriers, including financial barriers, which prevent the individual from accessing

identified health care interventions"; a social worker, a mental health worker, and "at least one other expert who could provide meaningful support and assistance to ameliorate the unbearable suffering of the individual [including hospice]..." The mental health worker is required to call in a second professional if necessary to assess competence; absolute power is given to the mental health workers to terminate the process if "impaired judgment" is discovered (the document does not say what to do if the mental health workers disagree about this, nor does it say whether the patient adjudged so impaired may dismiss the mental health worker and choose another).

To assure that no stone is left unturned in exploring alternatives to suicide, the proposal also mandates what seem to be a whole series of further referrals: "In addition to performing the tasks specified, each [emphasis added] of the consulting professionals will be responsible to offer a referral to a 'Personal Advocate,' [not defined] whose role it will be to assist the individual in accessing those support services which the individual chooses to pursue."

When all of these consultation are completed, assuming the individual is still alive, the Probate court then has an oversight role "to ensure compliance with the procedures."

Whether it is possible, not to say ethical and moral, to construct legislation whose restrictions are so onerous as to discourage people from using its provisions, is a question for philosophers and legal theorists. Questions of unconscionable conditions aside, it remains to be seen who would be eligible for the aid-in-dying privilege, and for what it would be that they are eligible. One can appreciate that under both proposals eligibility is not restricted to those with terminal conditions suffering unmanageable pain, but extends to those with degenerative diseases and "unacceptable" suffering, a term not defined other than by implication to exclude "a solely psychological condition." Would Mrs. Eddy be eligible? Would all of the AIDS victims? The promising vagueness of both the first and second proposals cannot be said to exclude that they might, though doctors fearing prosecution might prudently hesitate to certify them as eligible under the certification requirements. I would suggest however that any

"eligibility" criteria failing to meet the Mrs. Eddy test--a test based simply on the premise that someone who is going to kill herself anyway ought to have the right to be helped by her physician (without the physician being at risk of becoming a criminal)--is unsatisfactory.

More interesting is the question of what beneficiaries of the legislation would be eligible for. After publication of the Commission's report its chair, Howard Brody, a medical doctor who is also a thoughtful and respected professor of philosophy, published an article[28] expressing his disappointment. It was not the Commission's inability to offer guidance to the legislature that troubled him, but the lack of philosophical analysis in the Commission's three proposals. Citing recently published work, Brody pointed out two alternative methods of terminating life, both based on hospice techniques: Mrs. Eddy's route, refusal of nutrition with medical support; and "barbiturate coma," used to assist patients who fail to respond to more routine pain management, in which patients are rendered comatose until death occurs, often in a matter of hours. The question is whether either of these methods ought to be regarded as the "aid-in-

dying" whose protection is contemplated by the proposal. If not, then presumably these techniques are already legal, and it can be argued that no new legislation is required to bring aid-in-dying to patients in need. What would be decriminalized by the decriminalization proposal is crudities such as back-of-the-van carbon monoxide, which in any case Dr. Kevorkian has resorted to only since the cancellation of his medical license removed his access to lethal drugs. (Kevorkian's original "suicide machine" provided a self-induced fatal injection of potassium chloride.)

As well as being among the more 'liberal' states politically, Michigan is one of the states in the Union which are most advanced[29] in their discussion of the question of assisted suicide, and whose population is arguably among the most aware of the issues, so it might be hoped that in this state the assisted suicide question might be resolved through honest debate over the issues. The election has apparently assured that this will not happen, but that the forces in opposition, which are not limited to Right to Life, will carry the day. Advocates of decriminalization seem to be less "one issue"

oriented than those opposed. Disability advocates, adept at media manipulation, are at best suspicious of decriminalization.[30] Minorities, who were not present on the committee (no members and only two alternates were black) appeared before it to express their opposition.[31] The medical profession is evidently evenly--and passionately--split, and unlikely to go much beyond its current neutral position.

Those who are opposed in principle to any decriminalization will have to solve the problem of jury nullification, so it is unclear that the Legislature will gain anything by simply reenacting the present ban. But any legislation short of an outright ban purporting to clarify the status of assisted suicide likely to be subjected not only to restrictive procedural conditions but to tight definitions limiting who is eligible for the assistance and the kind of medical procedures that are protected; this could end up criminalizing procedures such as barbiturate coma and even assistance in refusal of nutrition which are presumptively legal even under the current prohibition.

Coda: A month after the release of the Commission's report, its chair and five co-authors published, in the prestigious New England Journal of Medicine,[32] a proposal for regulating physician-assisted death. The centerpiece of the proposal is mandatory counselling with a trained "palliative care specialist." No other counselling is required. The function of this consultant is partly medical but also partly judicial, as he or she is given appealable veto power over the decision (the consultant's veto can be appealed to a "palliative care committee," whose decision is final). There are at least two difficulties with the scheme: it is not clear on what grounds other than non-voluntariness the consultant could exercise the veto,[33] nor does the proposal discuss the problem of "forum shopping," ie, how patients could be prevented from selecting consultants known to be favorable to patient's expressed wishes. These difficulties aside however the scheme seems humane and workable with minimum intrusions and burdens, though its quasi-judicial apparatus would clearly not satisfy those proponents of assisted suicide who wish to see no outside interference on the exercise of the right to die. There is no evidence in the

Michigan Commission report that such a proposal was even considered by the Commission.

APPENDIX I: Members of the Commission

Michigan Commission on Death and Dying Members and Alternate Members and Officers

Howard Brody, Chairperson
Elsa Shartsis, Vice Chairperson
Deborah Cummings, Secretary

American Association of Retired Persons
Mable Meites, Member
Mary Alice Shulman, Alternate Member

American Civil Liberties Union of Michigan
Elsa Shartsis, Member
Ronald Bishop, Alternate Member

Citizens For Better Care
Marie P. Iverson, Member
Susan Titus, Alternate Member

Health Care Association of Michigan
Wanda Baad, Member
Helen Wentz, Alternate Member

Hemlock of Michigan
Daniel C. Devine, Member
Shaw Livermore, Alternate Member

Michigan Association for Retarded Citizens
Robert D. Aranosian, Member
Marjorie J. Mitchell, Alternate Member

Michigan Association of Osteopathic Physicians & Surgeons
Joseph A. Balog, Member
Melvin Linden, Alternate Member

Michigan Association of Suicidology
Kenneth T. Morris, Member
Alton Kirk, Alternate Member

Michigan Council on Independent Living
Penny Crawley, Member
John Sanford, Alternate Member

Michigan Head Injury Survivor's Council
Diane Kempen, Member
Benjamin Bolger, Alternate Member

Michigan Hospice Organization
Sue Wierengo, Member

Barbara Kowalski, Alternate Member

Michigan Hospital Association
Lisa Vandecaveye, Member
John Lore, Alternate Member

Michigan Nonprofit Homes Association
Thomas F. Schindler, Member
Ethel Stears, Alternate Member

Michigan Nurses Association
Margaret L. Campbell, Member
Denise Jacob, Alternate Member

Michigan Psychiatric Society
Arles Stern, Member

Michigan Psychological Association
Charles Clark, Member
Judith Kovach, Alternate Member

Michigan Senior Advocates Council
Larmar King, Member
Mary Payne, Alternate Member

Michigan State Medical Society
Howard A. Brody, Member

Thomas Payne, Alternate Member

National Association of Social Workers, Michigan Division

Deborah Cummings, Member

Peter D. Weidenarr, Alternate Member

Right to Life of Michigan, Inc.

Edward Rivet II, Member

Bernard Dobranski, Alternate Member

State Bar of Michigan

John D. O'Hair, Member

Martin L. Kotch, Alternate Member

Prosecuting Attorneys Association of Michigan

Patrick M. Shannon, Member

Richard Thompson, Alternate Member

APPENDIX II: Public Act no. 3, Public Acts of 1993
State of Michigan

Sec 7. (1) A person who has knowledge that another person intends to commit or attempt to commit suicide and who intentionally does either of the following is guilty of criminal assistance to suicide, a felony punishable by imprisonment for not more than 4 years or by a fine of not more than $2,000.00, or both:

(a) Provides the physical means by which the other person attempts or commits suicide.

(b) Participates in a physical act by which the other person attempts or commits suicide.

(2) Subsection (1) shall not apply to withholding or withdrawing medical treatment.

(3) Subsection (1) does not apply to prescribing, dispensing, or administering medications or procedures if the intent is

to relieve pain or discomfort and not to cause death, even if the medication or procedure may hasten or increase the risk of death.

(4) This section shall take effect February 25, 1993.

(5) This section is repealed effective 6 months after the date the commission makes its recommendations to the legislature pursuant to section 4.

Section 2. This amendatory act shall take effect February 25, 1993.

This act is ordered to take immediate effect.

NOTES

1. In preparing this paper I have had the benefit of conversation with three members of the Michigan Commission on Death and Dying: Howard Brody, MD, PhD; Fr. Thomas Schindler, PhD; Elsa Shartsis, JD. They are not of course responsible for the opinions expressed nor for any errors I may have made.

2. Though it has been widely reported that the statute has expired, whether it has or not is not entirely clear. The legislation required the Commission to report "within 15 months after the effective date of this act," ie, by May 23 1994. The section (#7) prohibiting "assistance to suicide" "is repealed effective 6 months after the commission makes its recommendations to the legislature." Because of legal challenges to the statute, the report issued by the commission dated 6 June may or may not be the report required by the statute to set the six-month clock running. The report itself was not issued as a document of the state of Michigan, but was published by the Michigan State Medical Society.

3. A recent *Detroit News* poll revealed that 57% of Michigan residents favor allowing assisted suicide under some restrictions, while 9% favor allowing it without restrictions. Only 30% favored an absolute ban.

4. NY Times, July 20 1994. The headline reads "A Woman Charts an Unusual Route to Death."

5. NY Times, June 14, 1994

6. Eddy, DM, "A Conversation with my Mother," Journal of the American Medical Association, vol.272:3, July 27, 1994, pgs. 179-81.

7. People v. Kevorkian, Detroit Recorder's Court, #93-10158. The jury verdict of acquittal was returned May 2 after a five-day trial. Thomas Hyde was the 17th of the 20 patients helped to die by Kevorkian.

8. Reason, May 1994, vol. 26:1, pgs. 40-41.

9. State of Michigan 87th Legislature, Public Act #3 of 1993, approved Feb. 25 1993.

10. The appeals process is still alive however, see note 5 infra.

11. NY Times, May 5 1994, pg. 1; National Law journal, May 16, 1994, pg. A6. Ruling (one day after the Michigan jury acquittal of Dr. Kevorkian) by Judge Barbara Rothstein, who held, not unreasonably, that if the 14th Amendment's guarantee of personal liberties protects the right to abortion from unwarranted state interference, it must protect the right of a "suffering ...terminally ill person" from the same interference. However Judge Rothstein held that under Supreme Court decisions governing abortion, the state could impose reasonable restrictions on the exercise of the right, and therefore refused to issue an injunction barring enforcement of the statute, on the books since

1854 but seldom enforced. (Compassion in Dying v. Washington, C94-119R).

12. The Court also bizarrely reinstated two murder charges, previously dismissed by lower courts, against Dr. Kevorkian. The court's 2-1 ruling was based on a 1920 case in which a husband was prosecuted for murdering his wife by placing poison within her reach and allowing her to drink it: "...aiding a suicide falls within the common-law definition of murder." These prosecutions have been stayed pending Michigan Supreme Court appeal. (NY Times May 11, 1994).

13. The Nonprofit Homes Association, which abstained on all three proposals. However their representative was said to be active in discussion.

14. "Final Report" of the Michigan Commission on Death and Dying, Appendix A, position statement of Michigan Association of Suicidology. June 6, 1994.

15. NY Times, Mar. 6, 1994: "The commission's vote was delayed for several hours when more than a dozen members of Adapt, a group advocating rights for the disabled, burst into the conference room in motorized wheelchairs, carrying signs saying 'Extermination without representation' and 'Hey-hey, ho-ho, this commissions has got to go!'"

16. American Medical News, Ap. 11, 1994, pg. 11.

17. In May the Michigan State Medical Society rejected attempts to put it on record either for or against a ban on physician assisted suicide, voting 85-32 to take no position. The MSMS had only the year before become the first state medical society in the nation to change its position from anti assisted suicide to neutral. (American Medical News Ap. 11, 1994). The policy adopted last year calls for physicians to exhaust every alternative before resorting to assisting suicide (Kalamazoo Gazette, May 8 1994). This neutral position is interpreted by some as affirming the individual physician's right to follow his or her conscience; protecting the privacy of the doctor-patient relationship seems to be the major concern of state medical societies. Outgoing MSMS president Gilbert Bluhm was quoted as saying that doctors need to make up their minds on the issue. However American Medical Association Chair Lonnie Bristow of San Pablo Calif has already made up his mind: "It is not ethical for physicians to take part in that kind of activity....abuses will occur." (American Medical News, May 16 1994). The national AMA has recently strengthened its position, calling assisted suicide "totally incompatible" with the ends of medicine.

In May also the Oregon Medical Association was unable to take a position on the ballot initiative to be voted on in November. The Association split virtually equally three ways: for, against, and "let the public decide."

However the Association "declined to reaffirm" the national AMA position opposing the participation of physicians in ending a patient's life. (American Medical News, May 16, 1994). And a recent study of doctors in Washington state showed equally deep divisions. (NY Times, July 17, 1994).

18. The full commission met 11 times at the state capital, and held 6 public forums at cities across the state. One procedural and five policy subcommittees were organized; these latter reported by Dec. 20, 1993. Three drafting committees reported at the meeting of Feb. 3, 1994. As a point of interest here, information was provided on the situation in the Netherlands by Dr. Herbert Cohen and Mrs. Jean Tromp Meesters of that country, and by Dr. Charles Gomez of Virginia, who has published a book on euthanasia in Holland. Additionally, I. John Keown of Queen's College and Ms. Demetra Pappas provided information on the Feb. 1994 report of the Select Committee of the British House of Lords.

19. "Final Report of the Michigan Commission on Death and Dying," Lansing, Michigan, June 8, 1994. (Bold type in original). Pages are not numbered. Due to the uncertain status of the establishing legislation, the legal status of the commission is unclear. Thus the report was issued not as a state document but by the Michigan State Medical Society, Lansing, Michigan, from whom copies may be obtained. References to the report indicated below as "Report".

20. The Legislature has begun to pass and the Governor to sign into law a series of acts designed to remove some of the obstacles to access to pain relief.

21. ibid.

22. The position of the Michigan Psychiatric Association appears to be stronger than the vote suggests. According to a letter published as part of the commission report, the Council of the MPS voted "Yes on removing the ban; abstain on allowing physician-approved physician-assisted suicide; no on allowing assisted suicide with counselling and 'safeguards.'" This appears to mean that the MPA either favors an absence of legislation (contrary to the implication in the report that there was consensus on the need for legislation), or legislation enabling assisted suicide but not imposing safeguards.
The letter from the MPA Council was provoked by its delegate voting contrary to her instructions. The Council removed its delegate and asked the Commission to change its vote.

23. A sub-group of seniors was also represented by Citizens for Better Care, which describes itself as "a state wide consumer advocacy organization concerned with the quality of life and the quality of care for the residents of long term care facilities..." Its position was that "decriminalizing assisted suicide WITHOUT assuring that those who choose to end their lives are aware of services which may be available would be wrong." (Report, Appendix A). This

led it to abstain on proposals both to decriminalize and to continue the ban, and to support only the second proposal, safeguards without recommendation. In contrast, the Senior Advocates Council voted yes on both the first and second proposals and no on the third.

24. Whose representative, John O'Hair, was himself a prosecutor who had prosecuted Dr. Kevorkian, though expressing personal opposition to the prohibition on assisted suicide. He was said to be a leader among the decriminalization group.

25. (Report, Appendix A).

26. Right to Life Michigan's statement fails to address the second proposal.

27. This proposal first attempts to address the fear of active euthanasia; it does so by what its summary calls "a definition of assistance with self-termination" to prevent active euthanasia: "Definition. The actual act which ends an individual's life must be carried out by the individual." However no definition of "actual act" nor of "carried out" is provided, and the distinction may seem hazy at best. Dr. Kevorkian placed the string to the CO machine in Thomas Hyde's hand. If Hyde then tried to pull the string but failed due to his ALS, then under the proposal one would have to say either that the correct procedure by Kevorkian would be to stop the intervention, detach Hyde from the machine and send him home; or, if this seems unpalatable, that once Hyde had begun

the act, or even attempted the act, then the "actual act" requirement is satisfied, and Kevorkian is free to pull the string. One can imagine similar hair-splitting with regard to injections.

It may be noted that as a philosophical question, whether passive acts such as refusal to eat are "acts" or merely "not doings" is probably an undecidable question. Thus if "an actual act carried out by the individual" is required to trigger the safeguards, it could be argued that a person who proposes to starve himself to death is not covered by the safeguards even if he requires the assistance of a physician to provide comfort and pian relief.

28. Brody, Howard, "Assisted Suicide in Michigan," Ethics-in-Formation (Michigan Health Care Network), sum. '94.

29. A commission in New York state has issued a report opposing legalization. New York State Task Force on Life and the Law: "When Death is Sought: Assisted Suicide and Euthanasia in the Medical Context." One main objection was that suicide would be granted inappropriately by doctors who are untrained to recognize or treat depression, (NY Times, May 26, 1994, pg. 1). Assisting someone to commit suicide is manslaughter in New York. The NY statute is being challenged in Federal court, Quill v. Koppell, 94 Civ. 5321. The plaintiff is the physician whose essay describing how he administered a fatal injection to a patient provoked both controversy and a criminal

investigation (National Law Jnl, Aug. 1 '94, pg A8).

30. A thoughtful article from the disability community's point of view is Paul Steven Miller, "The Impact of Assisted Suicide on Persons with Disabilities," Issues in Law and Medicine vol.9:1, sum '93.

31. One black witness was quoted as saying "I took an unscientific survey at my local working class bar...They said, 'Wilbur, we don't even trust doctors to keep us alive!'" NY Times, Mar. 6, 1994.

32. Miller, F. G. et al, "Regulating Physician-Assisted Death," New England Journal of Medicine, 331:2, July 14, 1994, pgs. 119-123.

33. Dr. Brody has informed my by letter that the intent is that the palliative care physician determine whether the patient has a medical condition justifying assisted suicide.

BIOGRAPHY

Joseph Ellin is a Professor of Philosophy at Western Michigan University, a member of the Ethics Center Board of Directors, and Vice-President of the Faculty Senate. He has recently published *Morality and the Meaning of Life*.

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